



LymphaCare

Lymphedema Pump Order Form

FAX ORDERS TO:
866-799-6863

EMAIL ORDERS TO:
FAX@LYMPHACARE.COM

Patient Name: _____ DOB: ____/____/____ DATE: ____/____/____

Patient Phone Number: _____ Height _____ Weight _____

Patient Address: _____ Home Other

**** PLEASE SEND PATIENT DEMOGRAPHIC SHEET ****
PLEASE SEND MEDICAL RECORDS FROM LAST TWO OFFICE VISITS

Primary Insurance: _____ ID# _____ Grp# _____

Secondary Insurance: _____ ID# _____ Grp# _____

PUMP ORDER: Segmental Non Gradient
 Gradient Segmental

APPLIANCES: Leg Right Left Bilateral 1/2 Leg
Arm Right Left Shoulder
Special Order Garment Vest Trunk Pants (custom)

MFG PREFERENCE (if applicable): BioCompression MediUSA Other

DIAGNOSIS:

- Q82.0 Primary Lymphedema
- I89.0 Secondary Lymphedema
 - Venous Insufficiency causing secondary lymphedema
 - Tumors Obstructing lymphatic flow
 - Scarring of lymphatic channels (due to cellulitis and/or Lymphangitis)
 - Cancer Surgery
 - Other: _____
- I97.2 Post Mastectomy
Date of Surgery: ____/____/____

PRESCRIBING PHYSICIAN:

Name: _____ NPI#: _____

Phone: _____ Fax: _____

OFFICE CONTACT FOR FOLLOW UP:

Name: _____

Phone: _____ Fax: _____